Office of the State Employer

AT-RISK ERGONOMIC ASSESSMENT REQUEST

EMPLOYEE COMPLETES THIS SECTION		
EMPLOYEE FIRST NAME	**EMPLOYEE LAST NAME**	**EMPLOYEE ID #**
DEPARTMENT/AGENCY	**JOB TITLE/CLASSIFICATION**	**EMPLOYEE GROUP** or **UNION**
WORK TELEPHONE	**WORK EMAIL ADDRESS**	**FLOOR & PILLAR NUMBER**
BUILDING NAME	**BUILDING ADDRESS + SUITE #** (if applicable)	**CITY**
COUNTY	**SUPERVISOR NAME**	**SUPERVISOR TELEPHONE**

AVAILABLE PARKING OPTIONS FOR THE SAFETY PROFESSIONAL/ERGONOMIC SPECIALIST

☐ Free parking ☐ Metered Street Parking ☐ Hourly Ramp Parking -- Location of Parking: _____

ACKNOWLEDGMENT

❖ I understand an At-Risk Ergonomic Assessment may not result in new equipment or work surface adjustments, and that my Department will determine the appropriate implementation of any suggestions for equipment or workstation adjustments.

_____ Employee Signature

_____ Date

REQUESTING PHYSICIAN COMPLETES THIS SECTION

An At-Risk Ergonomic Assessment requires the support and signature from a licensed physician (M.D. or D.O.) or doctor of chiropractic (D.C.); this program is not intended to address return-to-work situations, work-related injuries, or Disability Accommodation Requests based on a medical need. **Please print clearly and do not include a medical diagnosis.**

PHYSICIAN'S REQUEST

The above-named patient/State of Michigan employee is under my care and based on their medical condition, an ergonomic assessment is appropriate.

PHYSICIAN NAME	**LICENSE TYPE (M.D., D.O., D.C.)**	**CLINIC/OFFICE TELEPHONE**
CLINIC/OFFICE ADDRESS	**PHYSICIAN SIGNATURE**	**DATE**

DEPARTMENT DESIGNATED APPOINTING AUTHORITY REPRESENTATIVE COMPLETES THIS SECTION

CONTACT NAME	**EMAIL ADDRESS**	**WORK TELEPHONE**

HAVE INTERNAL ERGONOMIC PROCEDURES BEEN EXHAUSTED? ☐ Yes ☐ No

WAS FACT SHEET PROVIDED TO EMPLOYEE? ☐ Yes ☐ No

*****DISCUSS EMPLOYEE'S ROUTINE DUTIES AND PERCENT (%) VALUE WITH SUPERVISOR; % MAY NOT = 100%*****

IN A TYPICAL 40 HOUR WORKWEEK, HOW MUCH TIME DOES THE EMPLOYEE SPEND DOING THE FOLLOWING:

☐ Driving *(not daily commute)* _____
☐ Lifting & Carrying
- ☐ 0-10 lbs. _____
- ☐ 10+ lbs. _____

☐ Sitting _____
☐ Standing _____
☐ Other: _____

☐ Typing/Keying _____
☐ Using the Telephone _____

OTHER INFORMATION EVALUATOR SHOULD BE MADE AWARE OF

REQUESTED SERVICE

☐ Work Station Assessment ☐ Other (e.g., Lab, Mailroom, Vehicle, etc.): _____

_____ Department Designated Appointing Authority Representative Signature

_____ Date